THE COMMISSION ON INVESTING IN HEALTH 3.0:
CONCEPT NOTE FOR THE PMNCH BOARD

This concept note is presented to the PMNCH Board for consultation to take stock of progress and plans for the Commission on Investing in Health (CIH3), in relation to investments for women’s, children’s and adolescents’ health and well-being. It will serve as a basis for effectively framing, and disseminating evidence from CIH3, to advance advocacy and accountability for women, children, and adolescents, including the most vulnerable.

PMNCH, as a dedicated CIH3 partner, plays a pivotal role in coordinating and unifying partners around emerging evidence, as well as supporting knowledge generation and synthesis calling for increased investments for women, children, and adolescents. Its constituencies, champions, and channels serve as conduits for advancing advocacy based on robust economic and investment evidence, and supporting countries in prioritizing and investing in WCAH interventions within their national UHC plans. Effective leveraging of CIH3 evidence will contribute significantly to informing advocacy and policy action, promoting policy dialogue, and highlighting the economic benefits of such investments.

1. INTRODUCTION: THE 2013 CIH REPORT ("CIH 1.0")

The *Lancet* established a Commission on Investing in Health (CIH) in 2012 to mark the occasion of the 20th anniversary of publication of the World Bank’s [1993 World Development Report](http://www.worldbank.org) (WDR93), “Investing in Health.” The commission was chaired by Lawrence Summers, former US Treasury Secretary and President Emeritus of Harvard University and co-chaired by Dean Jamison at the University of Washington. Summers was the Chief Economist at the World Bank who commissioned WDR93 and Jamison led the report’s development.

The *Lancet* published the [first report](http://www.thelancet.com) of the CIH ("CIH 1.0") in 2013, titled “Global Health 2035: a world converging within a generation”. WDR93 pointed to new knowledge and tools—scientific advance—as underpinning the enormous improvements in human health that began in the mid-19th century and spread to most of the world. The CIH has, from its inception, further developed the theme of scientific advance and pointed to its implications for national opportunities and international action. GH2035 looked back at WDR93, its messages and its influence, and reviewed major changes in health conditions and in the global health landscape subsequent to 1993. It pointed to a great potential for well-chosen investments in health to achieve major impact by 2035.
A particular finding of the report was the technical and financial feasibility of a “grand convergence,” whereby most countries could achieve, by 2035, the low levels of maternal, child and infectious disease mortality that had already been achieved by the best performing middle-income countries. The report endorsed the general movement toward publicly financed, pro-poor universal health coverage (UHC) to achieve both better health outcomes and financial protection of populations. It departed from mainstream thinking on UHC by (i) stressing the need for selectivity in inclusion of interventions in health benefit packages (the CIH argued that the initial packages should include interventions for conditions that disproportionately affect the poor, i.e. tackling the “convergence agenda”); (ii) the need for public sector cost containment for health interventions outside UHC; and (iii) the implied transition of non-UHC intervention finance from the public to the private sector. To achieve grand convergence and UHC goals, GH2035 concluded that major but feasible increases in public finance would be required in many countries. When GH2035 was published, in 2013, the IMF was very optimistic about the economic growth of low-income countries (LICs) and lower middle-income countries (LMICs). Based on the IMF projections, the CIH estimated that around 1% of the economic growth of LICs and LMICs could fund the costs of grand convergence (these costs were estimated at about $70 billion per year). The CIH estimated that every $1 invested in the convergence interventions would yield $9 to $20 in return in LICs and LMICs.

A striking feature of the initial roll-out of GH2035 was the remarkable degree of support for the report’s key messages from multiple health and development agencies, disease advocacy communities (including the infectious disease and RMNCH communities), and many ministries of health, suggesting that convergence had resonance. For example, in his editorial in *The Lancet* that accompanied the CIH report, Mark Dybul, who at the time was the Global Fund’s Executive Director, wrote: “our replenishment themes are uncannily aligned with the key messages of the Commission’s report.” Jim Kim, who at the time was President of the World Bank, in a commentary in *The Lancet*, praised the report’s “conceptual clarity, empirical robustness, and ambitious recommendations.” Publication of the report was accompanied by an intense policy outreach strategy that actively engaged the Commissioners, both at national and international levels. For example, the CIH held in-country consultations with the governments of Mexico and India and published policy reports on the implications of Global Health 2035 for investing in health in these countries (e.g. see the paper *Salud Global 2035: Implicaciones Para Mexico*, in the journal *Salud Publica de Mexico*). The CIH successfully engaged a number of Commissioners in conducting very high-profile policy briefing events at major donor, advocacy, and country forums.

2. “CIH 2.0”: THE ALMA ATA AT 40 REPORT

A second report of the CIH (“CIH 2.0”) – called “Alma Ata at 40 years: reflections from the Lancet Commission on Investing in Health” – was published in the *Lancet* in 2018. CIH 2.0 looked back on the years subsequent to the influential Alma Ata Declaration on “health for all.” CIH 2.0 reviewed progress toward grand convergence. Progress was (substantial against HIV and child mortality, much less promising against tuberculosis and maternal mortality). Factors associated with progress included scale-up of existing evidence-based health interventions and the roll-out of new health technologies. The second report revisited and amplified GH2035’s arguments for a transition in international finance toward a strong emphasis on global public goods (particularly R&D) and control of cross border
negative externalities (e.g., pandemics, spread of pollutants, and spread of resistance to antimicrobials). Both CIH 1.0 and CIH 2.0 addressed prevention and treatment of noncommunicable diseases and injuries (NCDIs) and pointed to substantial potential for selected interventions (e.g., tobacco control) while documenting difficulties in achieving high rates of progress against these conditions.

CIH 2.0 proposed a “concrete notion of UHC that makes use of an explicitly defined, guaranteed, publicly financed set of essential health interventions.” It defined and costed two benefits packages—an essential UHC package (218 interventions, of which 198 could be delivered via primary care platforms) and a highest priority package (a subset of 108 interventions). Broadly, the SRMNCAH interventions focus on six pillars, namely under-5 mortality (e.g., childhood vaccination series, malaria prevention and treatment, promotion of breastfeeding); (ii) maternal mortality, (e.g., management of labor and delivery, tetanus toxoid immunization); (iii) prevention and treatment of neglected tropical diseases (e.g. mass drug administration for soil-transmitted helminthiases); (iv) family planning (e.g. provision of condoms and hormonal contraceptives, including emergency contraceptives, insertion and removal of long-lasting contraceptives); (v) water, sanitation, and hygiene measures, (e.g., community-led total sanitation, mass media messages concerning awareness on handwashing); and (vi) adolescent-friendly health services (e.g., provision of condoms to prevent STIs, provision of reversible contraception). The CIH 2.0 report also assessed the cost-effectiveness of these packages for low- and middle-income countries. The report found that such packages would be affordable for middle-income countries using domestic resources, but not for low-income countries.

3. “CIH 3.0”: GLOBAL HEALTH IN A POST-COVID WORLD

Rising geopolitical tensions, challenges to globalization, climate change, population aging, violent conflicts, and, most significantly, the COVID-19 pandemic have defined the years subsequent to the publication of CIH 2.0. Given that 2023 marks the ten-year anniversary of CIH 1.0, and that the global development landscape has changed so much during this past decade, Richard Horton, editor of The Lancet, invited the CIH to develop a CIH 3.0 report. The Bill & Melinda Gates Foundation and the Norwegian Agency for Development Cooperation have provided grant support for the work of CIH 3.0. PMNCH is partnering with the Commission on CIH 3.0.

This third report from the CIH will assess global investment in health in the post-COVID era. It will assess whether the world is on track to reach the “convergence” targets proposed in GH2035. We will examine progress over the last 10 years in tackling AIDS, TB, malaria, maternal and neonatal mortality, and child mortality, and will examine the technical feasibility, costs, and financing sources required to reach convergence. This examination will include ways to ensure equity and financial risk protection for the most vulnerable women, children and adolescents.

CIH 3.0 will also extend the time frame under consideration – from 2035 to 2050. CIH 3.0 will assess the feasibility of achieving “50 by 50,” i.e. a 50% reduction in premature deaths from the 2010 death rates by 2050 in each country. This work will be an update of a previous CIH study that examined the feasibility of “40 by 30” (a 40% reduction in premature mortality by 2030). Following similar approaches to those in CIH 1.0, in CIH 3.0 we will update the estimates of the economic value of improvements in mortality rates for the recent decade and calculate how much health gains contribute to economic welfare.
In CIH 3.0, there will be a major focus on “universality” in UHC, with serious attention to cost containment. We will examine the possible use of payroll taxes (rather than out-of-pocket payment or private voluntary insurance) to finance interventions that the public sector cannot or chooses not to cover for all with general revenue taxation. We recognize that attempts to provide financial protection by transferring inefficient private expenditure to the public account only preserves inefficiency.

COVID-19 reminded the world of the magnitude of ongoing pandemic risk — a risk that GH2035 had concluded that the world was failing to address. In CIH 3.0, we will update our previous analysis of the expected annual losses, in terms of deaths and economic welfare, from pandemics. We will also lay out lessons from successes and failures in controlling COVID-19. An important lesson of COVID-19 is that external finance and international solidarity may be highly limited, but of critical importance, especially for the lowest-income countries. In smaller countries, the benefits of pandemic preparedness and response may lie principally outside the host’s borders with important implications for domestic finance.

4. OPTIMISM DESPITE HEADWINDS

We remain convinced, as we were when GH2035 was published, that ever-improving technical capacity combined with probably continued economic growth offer the potential for major health improvements to provide major gains in human welfare. There is much to be optimistic about.

One reason for optimism is that we have seen important and impressive progress over the last decade in reducing child and maternal mortality and mortality from a range of infectious diseases, and we can accelerate progress by doubling down on delivering existing tools. In addition, premature mortality is largely due to a relatively small number of conditions that are amenable to health interventions, such as diarrheal disease, acute respiratory infections, AIDS, TB, malaria, and neonatal conditions. These conditions are preventable and treatable with today’s technologies. Most of the remaining differences in life expectancy result, again, from a small number of conditions that are also amenable to today’s interventions — ischemic heart disease, stroke, chronic obstructive pulmonary disease, and tobacco-and infection-related cancers.

A second reason for optimism is the revolution underway in global health R&D, especially in product development for neglected poverty related diseases, maternal and child health, and emerging infections. Many shifts—some of which are seismic—are likely to bring game-changing health technologies to affected communities more quickly and efficiently. Examples include innovations in funding R&D; artificial intelligence and machine learning; platform technologies, such as mRNA vaccines; modular manufacturing of vaccines; monoclonal antibodies for neglected and poverty-related conditions; and innovations in clinical trial platforms.

Nevertheless, while we remain optimistic about the opportunity for continued reductions in avertable mortality by 2035 and 2050, we recognize that there are stronger headwinds today than there were ten years ago. CIH 3.0 will examine—and will aim to quantify—some of these key headwinds, including the mortality and economic consequences of COVID-19, the climate crisis, debt crisis, and ongoing conflicts. Conflicts worldwide, including in Sudan, west Africa, Europe, and the Middle East, and US-China rivalry for hegemony in the western Pacific, have markedly altered the global environment. These crises are likely to increase energy prices, food prices, and debt (about $27 trillion in low- and
middle-income countries by 2022). We will probably see reductions in economic growth, development assistance, and the willingness of great powers to collaborate in addressing global challenges, including health challenges. There has also been a deterioration in public finance for health in many countries; a recent World Bank article stated: “The stark reversal in the priority given to health in government spending does not bode well for global health security and progress toward the health-related Sustainable Development Goals.”

GH2035 was anchored strongly to global goals and targets, such as “64-16-8-4,” the target of reaching an average of 64 maternal deaths per 1,000 live births, 16 child deaths per 100,000 live births, 8 AIDS deaths per 100,000 population, and 4 TB deaths per 100,000 population across all LICs and lower MICs by 2035. In contrast, the “center of gravity” of CIH 3.0 will shift towards countries and what kinds of national progress could be achieved by 2050 through focused investments. One way in which this focus will be apparent is through an examination of 20 of the best performing countries and 20 of the worst performing countries with respect to health improvements. In our analysis of where countries could hope to be by 2050, we will draw lessons from these high-performing and poor-performing countries.

CIH 3.0 will be a high-profile, ambitious project that aims to generate new evidence to guide health transformation in all countries. It will also help to reassert the primacy of investing in the health sector as an indispensable foundation for development. We believe that in the midst of so many overlapping crises, the time is right to give an up-to-date, state-of-the art assessment of the extraordinary value of investing in health.

5. EVIDENCE TO ADVOCACY

Evidence to inform advocacy and policy action is instrumental in supporting countries to prioritize and invest in WCAH interventions as part of national UHC plans, especially if centered around primary health care as a cornerstone of sustainable and equitable health systems.

PMNCH will leverage the emerging economic evidence and partnership with CIH3 to socialize the emerging findings during the World Health Assembly 2024. Furthermore, it will support knowledge synthesis, advocacy and financial accountability at global, regional and national levels, for equity-enhancing policy, financing and service delivery to accelerate progress for women, children and adolescents in the last years of the SDG era.

At the halfway point of the 2030 Agenda, PMNCH’s 2024-2025 strategic priorities will be based on advocacy and accountability informing policy debates, legislations and decisions to accelerate progress for WCAH founded on this emerging data. Opportunities to leverage political advocacy moments in 2024, including the WHA77 resolution on women’s, children’s and adolescent health, will require framing and alignment across PMNCH constituencies to ensure a unified and powerful approach. Further moments for engagement are considered with global and regional financing platforms such as WEF 2024, ICPD30, G7 and G20.